PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D29

PROVIDER –
Boone County Hospital
Boone, Iowa

Provider No. 16-0026

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING-
October 24, 2001

Cost Reporting Period Ended
June 30, 1995

CASE NO. 98-0452

INDEX

ISSUE:

Did the Provider qualify for a payment adjustment due to a decline in its discharges for fiscal year ending June 30, 1995?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Boone County Hospital (Provider) is a governmental county hospital located in Boone, Iowa, approximately 45 miles northwest of Des Moines, Iowa. It is located in a rural area, is not part of a metropolitan statistical area, and has Medicare utilization that is greater than sixty percent. The Provider is licensed for 57 beds and has been designated a Medicare Dependent Hospital (MDH) since 1990.

The Provider's current fiscal Intermediary is Cahaba Government Benefit Administrators. It replaced Wellmark, Inc., and Blue Cross and Blue Shield of Iowa, Inc. All of the above have acted as the Provider's Intermediary since the filing of the Provider's volume decline application on August 7, 1996. These entities are individually and collectively referred to as the Intermediary.

On August 7, 1996, the Provider filed a volume decline application with the Intermediary requesting payment of an adjustment amount of $545,851 for fiscal year ending June 30, 1995 (FY 95), pursuant to Section 1886(d)(5)(G)(iii) of the Social Security Act. At the hearing, the parties stipulated that if the Provider prevails, it should be paid $491,303.[1]

On February 7, 1997, the Intermediary informed the Provider of its initial conclusion that the Provider did not qualify for the payment adjustment since "the data submitted does not establish that at least five percent of the decrease resulted from an unusual situation, or occurrence that was beyond the hospital's control."[2] On February 12, March 6, and July 25, 1997 the Provider supplied additional information to the Intermediary.[3] Over the course of several months, despite repeated attempts by the Provider and Intermediary to reconcile the positions of the parties on this matter, no agreement was reached. On August 6, 1997, the Intermediary advised the

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[1] Transcript (Tr.) at 6.

[2] See Intermediary Exhibit 1.

[3] Id.

Provider it was denying the Provider's request and further advised the Provider of its appeal rights under Chapter 29 of the Provider Reimbursement Manual.

On December 10, 1997, the Provider filed a timely request for hearing to the Provider Reimbursement Review Board (Board). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by Dennis M. Barry, Esquire, of Vinson & Elkins. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that Section 1886(d)(5)(G)(iii) of the Social Security Act was enacted to support and protect rural hospitals. The purpose of this statutory provision is to aid MDHs so that they can stay open and maintain services for their communities. Congress has recognized that these hospitals are a vital link in the national system, and that maintaining these hospitals and protecting their revenue is vital to maintain access for Medicare patients in rural communities. The statutory amendment that extended the volume adjustment to MDHs was Section 6003 of the Omnibus Budget Reconciliation Act of 1989. Its intent to support and protect rural hospitals is apparent since that same section included other provisions addressed to rural hospitals, including: increasing the update for rural facilities by 4.22 percent (compared to a large urban update of 0.53 percent); authorizing disproportionate share (DSH) payments for certain rural hospitals; extending the rural referral center classification; making permanent the authority to pay sole community hospitals an additional amount when there is a 5 percent volume reduction; provisions related to MDHs; and establishing Essential Community Access Hospitals for rural areas. The statute specifically states that if a rural hospital experiences, in a cost reporting period compared to a previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the provider is entitled to an adjustment. The key phrase is "circumstances beyond its control." Congress did not use the words "extraordinary circumstances," "unusual situation or occurrence" or "unique circumstances" which the Intermediary argues is the applicable test. Those words are used in other exception situations, but not in the statutory test applicable for granting a volume decline adjustment for MDHs. It is acknowledged that there is a standard for exception relief because of "extraordinary circumstances" for purposes of cost limitations under 42 C.F.R. § 413.30(f)(2) and TEFRA target amounts under 42 C.F.R. § 413.40(g)(2), but this standard does not apply in the case of volume adjustment protection.

The Provider observes that under 42 C.F.R. § 412.108(d)(2), the applicable regulation for volume adjustment payments for MDHs, a hospital must submit documentation to the intermediary demonstrating the size of the decrease in discharges and show that the decrease is due to circumstances beyond the hospital's control. The Intermediary has acknowledged that the regulations mirror the statute.[4] Again, the literal wording of the regulation does not support

[4] Tr. at 24.

imposing a standard for relief for MDHs experiencing a decline in volume as stringent as the standard under both the cost limitations and the TEFRA target amounts. 42 C.F.R. § 412.108(d)(2) requires only that the circumstances that are the basis for relief be "beyond the hospitals' control."

The Provider notes that showing that the decline in admissions is beyond the hospital's control is the only requirement in the statute and regulation. Once an MDH establishes that it experienced at least a 5 percent drop in admissions, which is not in dispute in this case, the hospital is entitled to relief unless the reason for the decline in admissions was not beyond the hospital's control. Stated affirmatively, when a hospital shows the drop in admissions and shows that it was not its fault, it is entitled to this relief. Notwithstanding its agreement that the Provider's greater than 5 percent decline in admissions was beyond the Provider's control, the Intermediary has relied upon Provider Reimbursement Manual (HCFA Pub. 15-1) § 28l0.l and its interpretation to that section as a basis for denying the Provider's request. That section states:

> Circumstances Beyond the Hospital's Control.—In order for an SCH to qualify for additional payment, the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects.

Id.

HCFA Pub. 15-1 § 2810.1 does not explicitly state that it applies to MDHs. Not only does the statute define MDHs and SCHs as mutually exclusive of each other, but HCFA has also consistently treated them as such. Section 1886(d)(5)(D)(iii) of the Act provides that an SCH is any hospital that the Secretary determines is located more than 35 road miles from another hospital or is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under Medicare Part A. In contrast, an MDH is defined in Section 1886(d)(5)(G)(iii) as any hospital located in a rural area, that has not more than 100 beds, that is not classified as a sole community hospital, and for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report was attributable to inpatients entitled to benefits under Part A. By the very terms of its definition, an MDH is not an SCH.

The Provider contends that this Manual section is unnecessarily complicated since it introduces language similar to the language appearing in Manual sections explaining the circumstances justifying exception or adjustment relief under the cost limitations or target rates when it is clear that the statute and regulation do not impose nearly so high a standard. However, there is nothing in the literal wording of this Manual section that bars granting relief in the Provider's

circumstances. To the extent that HCFA Pub. 15-1 § 2810.1 applies to MDHs, the focus should be on the literal disjunctive test set forth in this section. It states that "the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control." Id. The critical word in that test is "or." If either an unusual situation took place or there was an occurrence externally imposed upon the hospital and beyond its control that led to the decrease in volume, a Provider is entitled to volume adjustment relief. The Intermediary has testified that it agrees with the interpretation that if a provider were to show that there were occurrences externally imposed on it and beyond its control, it would qualify for exception relief, regardless of how usual or unusual that might be.

In summation, the Provider observes that the Intermediary witness' interpretation of the Manual language at the hearing was that "unusual" did not modify an occurrence externally imposed on the hospital and beyond its control. Yet the Intermediary's basis for denying the Provider's request was that the Provider's situation was not "unusual."[5] To the extent that "unusual" in the Manual is interpreted as modifying "occurrence externally imposed on the hospital and beyond its control," the Provider believes the Manual impermissibly restricts the relief expressly made available by the express wording of the statute and regulation. Even then, however, for the reasons discussed below, the Provider believes that it meets the more stringent standard of the Manual as interpreted by the Intermediary.[6] Based upon the explicit admissions of the Intermediary in testimony, the Provider is entitled to a volume decline adjustment.

The Provider observes that during FY 95, the Provider experienced a 7.76 percent (1543 to 1415) decrease in discharges compared to its fiscal year ending June 30, 1994 (FY 94).[7] The number of discharges and corresponding percentage decrease are not in dispute.[8] In FY 94, the Provider had total net income of $560,000 and net operating income of $504,400.[9] Based on this level of income and experience from FY 94, the Provider budgeted for a slight increase in admissions for FY 95. However, the anticipated budgeted amount for FY 95, based on admissions during FY 94, did not materialize, and the Provider had total net income of only $132,000 and operating income of only $24,900 for FY 95.[10] This was approximately $600,000 less than what the Provider had included in its budget.

The Provider notes that it first became aware in FY 95 that there was a drop in inpatient

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[5] See Intermediary Position Paper, p. 6, Intermediary Exhibit 1 and Tr. at 252.

[6] Tr. at 252-57.

[7] Tr. at 64; Provider Exhibit 2.

[8] Tr. at 245.

[9] Tr. at 54 and Exhibit 15.

[10] Tr. at 55; Provider Exhibit 15.

admissions in November 1994. It was then that Mr. Smith, the Provider's chief executive officer (CEO) approached the physicians on the medical staff to determine the cause for the change in hospital utilization, and whether the Provider was at fault for the decline in admissions.[11] The physicians had no complaints about the availability of the Provider's services or equipment or the quality or capability of the staff technicians or nurses.[12] The statements submitted by physicians either state expressly that the Provider did nothing to cause the decline in their admissions or fail to cite any problem with the Provider when explaining the reasons for the decline in admissions.[13] The CEO was not aware of any change in Medicare or other third party payor coverage policies or the interpretation of these policies in 1995 that would have adversely affected inpatient admissions.[14] Furthermore, there was no change in the very small managed care market penetration in the Provider's market area in 1995 that would have impacted inpatient admissions.[15]

Although the Provider in its original application claims that the "utilization of advanced technology has allowed the doctors to treat a larger portion of their patients on an outpatient basis,"[16] the Provider observes that its percentage of outpatient revenue decreased slightly from FY 94 to FY 95 (decrease from 48.2 percent to 48.1 percent), while there was an approximate price increase of 6 percent, and operating revenue declined from the prior year. Thus, outpatient volume also decreased.[17] From FY 94 to FY 95, there was no change in the procedures physicians could have performed in their offices.[18] The CEO was not aware of any services that were being furnished in physician offices that were substituting for inpatient admissions.[19] Thus, the drop in inpatient admissions cannot be explained by a substitution of outpatient services for inpatient services.

The Provider observes that in November 1994 and on subsequent occasions, the CEO discussed the reasons why there was a decline in discharges with various physicians. Of the 119 cases

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[11] Tr. at 57-62.

[12] Tr. at 59-60.

[13] See Provider Exhibits 12A, 12B, 12C and 12D.

[14] Tr. at 61-62.

[15] Tr. at 62.

[16] See Provider Exhibit 2, p.2.

[17] Tr. at 124.

[18] Tr. at 124-125.

[19] Tr. at 126.

constituting the total decline in inpatient cases, the Provider needs to show only that 77 (5 percent) were the result of circumstances beyond its control. The decline in discharges is described below for specific physicians who are grouped together according to similar circumstances in relation to the Provider for FY 95.

On or about January 1, 1994, Drs. Murphy, Volker and Sutton joined Integra Health, a large group practice,[20] in order to avail themselves of better physical office space which they expected would not only help in the delivery of health care services but also help attract new physicians recruits.[21] These three physicians moved into a new office building provided by Integra Health at the beginning of FY 95. However, the move to Integra Health by these three physicians was not without its problems. As Dr. Murphy points out in his April 8, 1996 letter,[22] and his affidavit,[23] because of his move to a large medical group, he had far less support in his office in terms of administrative activities and, as a result, was not able to maintain his patient volume. He had to do more personal secretarial work than before. Dr. Murphy was unable to see all the patients who requested to see him because of the staffing inefficiencies at Integra.[24] The Intermediary originally agreed with the Provider that the circumstance of Dr. Murphy moving from a solo practice to part of a large medical group is considered a circumstance beyond the Provider's control which would account for 29 fewer discharges or a 1.89 percent decrease in discharge volume.[25]

The Provider observes that Dr. Volker is in agreement with Dr. Murphy that joining a group practice resulted in certain inefficiencies. When he joined Integra Health, Dr. Volker engaged in a pilot program of paperless recordkeeping which necessitated the keeping of duplicate sets of records. This change in recordkeeping resulted in increased paperwork rather than the intended benefit of decreased paperwork and increased efficiency. As a result, Dr. Volker saw fewer patients after joining Integra Health, which resulted in a corresponding decrease in inpatient admissions.[26] Dr. Volker even closed his practice to new patients to accommodate these inefficiencies.[27] As a result of these inefficiencies, the number of office visits for Drs. Murphy

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[20] Tr. at 83, Provider Exhibit 12A.

[21] Tr. at 78.

[22] See Provider Exhibit 2C.

[23] See Provider Exhibit 12A

[24] Tr. at 159, Provider Exhibit 13.

[25] Intermediary's Position Paper, p. 7

[26] See Provider Exhibit 14.

[27] Tr. at 184, Provider Exhibit 12B.

and Volker collectively declined from 7,737 in FY 94 to 5,488 in FY 95.[28]

The Provider further observes that Dr. Sutton began transitioning toward retirement as soon as he joined Integra. He merged with the group practice as a way of "selling" the assets of his practice before his retirement. He experienced the same inefficiencies that confronted Drs. Murphy and Volker.[29] In addition, there were scheduling problems encountered by the staffs of these three physicians in the transition from a non-computerized system to an electronic scheduling mode used by Integra.[30] Billing personnel had difficulty assimilating into a large group practice as they similarly had to adapt to using a computerized system.[31] In summary, the fact that Drs. Murphy, Volker and Sutton joined Integra Health and experienced certain inefficiencies in practice which resulted in a decline in office visits and a corresponding decline in inpatient admissions were circumstances beyond the Provider's control. These three physicians, who had admitting privileges at only the Provider and who were fiercely loyal to the Provider,[32] account for a decline of 81 admissions, which exceeds the admissions that would be necessary to establish a decline of 5 percent from the preceding year.

The Provider further observes that Drs. Messerly and Sundberg are two general surgeons who had previously practiced with Drs. Murphy, Volker and Sutton. When those three physicians joined Integra, these two surgeons formed their own practice, Mid-Iowa Surgery, during FY 95. Dr. Sundberg stated that there was a change in the alignment of some of the primary care physicians which resulted in many patients that would have typically been taken care of by Drs. Messerly and Sundberg being sent elsewhere in accordance with certain group practices.[33] Dr. Messerly mirrors the comments of Dr. Sundberg and points out "[t]he expansion of two regional medical groups into Boone caused physicians in those groups, particularly McFarland Clinic, to refer to their own surgeons."[34] When Dr. Vermillion joined the McFarland Clinic in August 1994, he started referring some patients to Dr. Menzel, a McFarland Clinic surgeon, as opposed to referring to Drs. Messerly and Sundberg.[35] Partially as a result, discharges from the Provider attributable to Drs. Messerly and Sundberg decreased.

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[28] See Provider Exhibit 12, p. 6.

[29] Provider Exhibit 12, p. 6.

[30] Tr. at 102.

[31] Tr. at 101.

[32] Tr. at 68, 104.

[33] See Provider Exhibit 12C.

[34] See Provider Exhibit 12D.

[35] Tr. at 117.

The Provider further contends that there were a number of changes in physician affiliations in 1995 and, as Mr. Smith testified, this was extremely unusual, particularly in a community where physicians who were in private practice for twenty or twenty-five years were faced with undergoing a fundamental change.[36] A number of changes which occurred within the medical community had an effect on referrals, resulting in both a decline in admissions and some patients being admitted to other hospitals.[37] Some shift in referrals is supported by a statistical analysis of the change in discharges for the Provider and Mary Greeley Hospital.[38] Mary Greeley Hospital had an increase of 68 discharges, while Boone had a corresponding decrease of 51 discharges for these two surgeons. This decrease in discharges was in no way attributable to the Provider and was due to circumstances beyond the Provider's control.

The Provider contends that there is nothing in the volume decline statutory or regulatory provisions which requires a hospital to engage in physician recruitment when there is a decline in admissions. However, the Provider does recognize that the relevant preamble language and HCFA Pub. 15-1 §2810.1 do list the inability to recruit physician staff as one of the situations which would justify a volume decline adjustment. Despite all the recruitment efforts of the group practices in the Boone County community and the Provider throughout the early and mid-1990s, as described below, the Provider still was not able to recruit essential physician staff, particularly primary care physicians[39] that would have been able to prevent the decline in inpatient cases in FY 95.

The Provider observes that Boone Medical Specialties was a small medical group in Boone which had recruited two physicians, Dr. Lorentzen and Dr. Clemons, in the late 1980s through the early 1990s. When Dr. Lorentzen left the group but still wanted to remain in practice in the community, the Provider found her office space within the hospital and loaned her $70,000 to help her cash flow until collections on her billings could sustain her ongoing practice.[40] Furthermore, when Dr. Clemons failed to assimilate into private practice, the Provider arranged for him to have office space in the hospital and agreed to have him work in the emergency department.[41]

The Provider states that it encouraged physician practices to maintain their ongoing recruitment

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[36] Tr. at 138-139.

[37] Tr. at 145-146.

[38] See Provider Exhibit 12E.

[39] Tr. at 129-130.

[40] Tr. at 85.

[41] Tr. at 86-90.

activities. The Provider had a strategy of not itself recruiting physicians to be employed by the Provider, but instead encouraged physicians within the community to engage in recruitment of new physicians. When the limited number of recruits arrived in Iowa, the Provider would pay for transportation and housing.[42] This strategy of encouraging and assisting community physicians in recruiting new physicians to the community was desirable for a number of reasons. As noted in a published analysis of physician recruitment, recruitment by a physician practice is much more likely to be successful and it will cost less than recruitment by a hospital for employee physicians. Group Practices Tie Hospital, Physician Objectives, HFMA Journal (Aug. 1990) at 21.[43]

The Provider observes that when its financial condition began to improve in calendar year 1995, it did provide signing bonuses of $10,000 each for two physicians who joined existing practices in the community.[44] The bonuses were met with mixed reviews from members of the medical staff. The physicians who benefited by having a new physician were supportive. Some of the older physicians resented the bonuses since they had not received similar financial help when they began their practices.[45] Worksheet A-8 of the Provider's FY 95 cost report[46] contains a line item 6 which shows $29,079 as recruitment expenses, which included the bonuses and other incidental recruitment expenses.

The Provider observes that the Intermediary has denied the Provider's application for relief because it asserts that the Provider was experiencing competitive problems and also that its circumstances were not "unusual." The Provider believes that the Intermediary's argument is not factually supported. It is clear that inpatient admissions were not diverted from the Provider to physician offices in the community. First, a physician office could not substitute in any community for inpatient services. In any event, the type of services furnished by the physician offices in Boone County are not complex and could not have substituted for inpatient admissions at the Provider.[47] It is also clear that the physicians in the community continued to admit their patients to the Provider.[48] Primary care physicians in Boone County did not even have active medical staff admitting privileges at any other hospitals.[49] Thus, the only effect that the

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[42] Tr. at 94-96.

[43] See Provider Exhibit 12H.

[44] Tr. at 97.

[45] Tr. at 97-99.

[46] See Provider Exhibit 1.

[47] Tr. at 124-126.

[48] Tr. at 69.

[49] Tr. at 68.

affiliation of physicians in Boone County could have had is on those patients who would have been referred to other physicians. Further, Drs. Murphy, Volker, and Sutton joined the Integra Group. That group was not owned by another hospital.[50] Its closest other location was in Des Moines which was more than 45 miles away.[51] This was a state-wide group of primary care physicians and did not include the specialties to which referrals would usually be made.[52] There is no evidence in the record that patients were being referred by physicians in Boone County to Des Moines for hospital services that could have been furnished at the Provider. Moreover, there is no reason to infer that such referrals may have been made. Patients and their families would resist driving 45 miles for the sort of hospital services that could have been just as well furnished in the local facility.

The Provider notes that it is correct that the two surgeons, Drs. Messerly and Sundberg, explained that their drop in admissions was caused by a change in referral patterns from primary care physicians in Boone County to other surgeons, and they understood that patients were being referred to a surgeon in Ames affiliated with one of the groups that had acquired a practice in Boone. The physicians who joined the Integra Group, Drs. Murphy and Volker were clear in their affidavits that their referrals to other physicians did not change.[53] It seems likely that the physicians referring patients would have been more familiar with where they were referring their patients than the physicians receiving referrals. It is possible that the surgeons were the victims of a general slow down in primary care physician productivity in Boone just as the Provider was, and that the surgeons assumed that there had been a change in referral patterns. But even if it is assumed that there was a change in referral patterns and that caused in its entirety the decline in discharges for the surgeons, there was still well over a 5 percent decline in discharges, 77 discharges, for primary care physicians Drs. Murphy, Volker, Sutton and Clemons. This does not even take into account the decline in admissions attributable to Dr. Vermillion and Dr. Hardinger. Thus, even if one accepts the Intermediary's argument that the "natural workings" of competition do not fall within the scope of circumstances for which relief may be granted, at least a portion of the Provider's decline in admissions, a decline of more than 5 percent, had nothing to do with competition.

The Provider contends that the Intermediary's "competition" theory is not factually supported. But even if it were factually supported, there is nothing in the law, regulation or Manual that disqualifies MDHs suffering from the effects of competition from better funded and larger providers in larger communities from qualifying for relief. When, as here, there is not a scintilla of evidence in the record that the Provider did anything to repel physicians or otherwise fail to do what it should have done, relief should be granted. The record is clear that there were no

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[50] Tr. at 71.

[51] Tr. at 71 and 9.

[52] Tr. at 72-73.

[53] See Provider Exhibits 13 and 14.

complaints about the quality of the Provider's care, the qualifications of its personnel, or its ability to work with admitting physicians.[54]

The Provider observes that market share data[55] also show that the decline in admissions cannot be fully explained by residents of Boone County, the Provider's service area, going to other hospitals.[56] Those data report:

Calendar Year	Provider's Market Share
1993	40.6%
1994	40.3%
1995	41.0%

The data are also consistent with the explanations from the physicians that the severe dislocations related to the move from their prior practices to the new practices substantially interfered with them seeing patients. The physicians moved to new practices in the middle of calendar year 1994, the beginning of the Provider's FY 95. Thus, the calendar year data show a drop in the Provider's market share in 1994, with a recovery in calendar 1995. If the reason for the drop in admissions had been competitive issues, the Provider's market share should not have recovered so quickly in calendar 1995. In addition, if the problem had been referrals from the physicians joining new practices to their new partners outside of the community, those referrals should have increased with greater familiarity and confidence in their new partners. The data do not reflect that.

The Provider notes that the Intermediary witness' testimony that other physicians in Boone County could have taken up the slack for the physicians who were experiencing problems in their practice is, by the Intermediary's own admission, not supported by any "guideline." Nor is it supported by any empirical evidence of how many physicians are needed for an area or any demographic information at all. The witness stated in response to the question of how it is determined how many physicians are needed in a community that "there's really no guideline."[57] The Intermediary also states that the test that it applies for whether the loss of a physician to a community causes a decline qualifying a hospital for relief is based solely on whether the hospital experiences a decline of 5 percent or more in its discharges.[58] The sole distinction between this case and what the Intermediary testified to is that no physician left the community.

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[54] Tr. at 59-60 and Provider Exhibits 12A, 12B, 13C and 13D.

[55] See Provider Exhibit 16.

[56] This data is for calendar years and the Provider's data is for its fiscal year end of June 30. Thus, the year at issue, FY95 began July 1, 1994.

[57] Tr. at 256.

[58] Tr. at 257.

Rather in this case, one physician was in the process of self-destructing his practice notwithstanding the Provider's furnishing him with office space after his former partners disassociated with him, and at least three other physicians have explained that they experienced serious dislocations in their practices as a result of moving to a new setting and a new organization. The Intermediary witness attempted to make light of the dislocations associated with that practice transition, but the fact is that the physicians documented in their affidavits that their office visits declined by 2,249, or 29 percent.[59]

INTERMEDIARY'S CONTENTIONS :

The Intermediary contends that the Provider is looking for no fault relief in that as long as the decline in discharges cannot be affirmatively blamed on the Provider, the Provider is entitled to the adjusted payment.[60] To refute this alleged argument, the Intermediary cites the same preamble discussion from the Federal Register as cited by the Provider.[61]

> The basic test for evaluating a hospital's request for special payment due to circumstances beyond its control (in this case, a decrease in volume) is whether the decrease in volume is the result of an unusual situation or occurrence that is both externally imposed on the hospital and beyond its control. These situations may include, but are not limited to, strikes, fires, floods, inability to recruit essential physician staff, unusual, prolonged and severe weather conditions that affect the local economy, the closing of a major employer in the hospital's service area resulting in decreased population or loss of inpatient health insurance coverage for large numbers of people, and similar unusual occurrences with substantial cost effects.

55 Fed. Reg. 15150, 15155 (April 20, 1990).

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[59] See Provider Exhibit 12, p. 6.

[60] Tr. at 22-23.

[61] Tr. at 24-26.

The Intermediary explains that when a general word or phrase follows a list of specific persons or things, the general word or phrase will be interpreted to include only persons or things of the same type as those listed. Applying *ejusdem generis* to the preamble discussion, the Intermediary contends that examples of an unusual situation or occurrences that is both externally imposed on the hospital and beyond its control in justifying a payment adjustment can be broken down into three separate groupings. The first set includes circumstances or occurrences that makes the hospital either physically inoperable or physically inaccessible to its patient constituency (severe weather, floods, fire, or strikes). The second set includes economic circumstances which are either changes in the community business environment that cause the patient population to decrease or materially alter the level of financing for health care coverage which lead to the deferral of elective types of procedures. The third set includes the inability to recruit essential physician staff.[62] The Intermediary argues that none of the above situations or occurrences are the cause of the Provider's decline in discharges. Whatever the cause of the Provider's decline in discharges, it simply was not the type of circumstance or occurrence articulated in the preamble which would justify granting a payment adjustment.

The Intermediary observes that while it has granted various volume decline payment adjustments for other providers which have experienced a decline in discharges when physicians have left the community, the Intermediary believes that these situations are distinguishable from the instant case.[63] The Intermediary assumes that the patients turned away because of the scheduling practices at Integra Health and were able to receive patient care elsewhere. The Provider gives no affirmative proof to refute this assumption.[64] The Intermediary argues that dealing with new computer systems and office inefficiencies which were encountered at Integra were not unusual, and that there will always be a period of adjustment. However, the Intermediary's witness concedes that he has no personal knowledge of what a common adjustment period would be or what transitions or problems would be expected.[65] The Intermediary also contends that there is no direct correlation between these problems and a decline in inpatient admissions.[66]

The Intermediary argues that a shift in market share or the workings of competition are not the types of factors which would justify granting the Provider's volume adjustment application.[67] However, as the Provider's witness testified, the Provider's market share of inpatient discharges changed very little from 1994 through 1996. In 1994, the market share percentage was 40.3

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[62] Tr. at 29-32.

[63] Tr. at 225-227.

[64] Tr. at 227, 257.

[65] Tr. at 263.

[66] Tr. at 229.

[67] Tr. at 33.

percent; in 1995, 41 percent; and in 1996, 39 percent. These numbers do not support any significant decline in market share.

The Intermediary observes that the implementing regulation at § 412.108(d)(2)(ii) requires the applicant to "show that the decrease is due to circumstances beyond the hospital's control." When the regulation was issued, the accompanying Federal Register interpretive explanation[68] was a basic test as addressed above. A similar adjustment is available to a Sole Community Hospital. See 42 C.F.R. § 412.92. The regulation uses the same requirement of showing that the circumstances were "beyond the control." HCFA Pub. 15-1 § 2810.1, which specifically related to SCHs, cites the same tests and examples as the above-cited Federal Register articulates. As the evidence and testimony substantiated, the area physicians whose drop in admissions from FY 94 to FY 95 contributed substantially to the overall 7.7 percent decline. All directly or indirectly stated that there was nothing affirmatively that happened at the Provider which precipitated a decision not to admit patients.

The Intermediary notes that the Provider's argument was really that the standard was "no fault." Since the hospital could not be blamed, the granting of the adjustment was automatic. The Intermediary argues that the regulation's standard as interpreted in the preamble required more than innocence. Definable situations or circumstances must be captured, and there must be causation established. The examples listed, while not exhaustive, evidence the need to show cause and effect beyond natural marketplace workings.

The Intermediary observes that when there is an "unusual situation or occurrence," the event should be reasonably evident. For example:

a. A physician leaves a community and is not replaced immediately in spite of good efforts. This will affect a hospital's case load.
b. A plant closes and insurance coverage ceases. It is a reasonable expectation that admissions will drop.
c. A fire effectively closes half the hospital beds for six weeks. The capacity is cut and patients must go elsewhere.

The theme of the above is cause and effect. Nothing close happened at the Provider.

The Intermediary observes that discharges were dropping and were not discovered until almost four months into the fiscal year.[69] The reasons were elaborated on after a series of talks with physicians.[70] The circumstances speak against identifying a qualifying event or events under the regulation. Three of the physicians mentioned, Drs. Murphy, Volker, and Sutton, stayed in the

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[68] See Intermediary Exhibit 4.

[69] Tr. at 55.

[70] Tr. at 57.

city of Boone, but began participating with Integra, a large group practice located in Des Moines.[71] That change obviously had an impact on their practices, but the doctors were as accessible as before. Another doctor seemed to have personality clashes with other physicians and hospital staff. That is hardly unusual.[72] Doctor Vermillion was also a topic of discussion. While not changing his office location, he became affiliated with the McFarland Clinic.[73] The surgeons who the Provider identified primarily as contributing to the problem tied their drop in admissions to the affiliation changes regarding Integra and the McFarland Clinic.[74]

The Intermediary observes that the drop in discharges was difficult to correlate to the explanations. The Provider's witness acknowledged that patients in a medical state that required attention received care.[75] The impact of practice environmental changes brought about by the new affiliations affected non-urgent care. Further, after reviewing the documented explanations submitted by the physicians or the Provider prior to the live hearing and considering the testimony offered by the hospital administrator, any reviewer would be challenged to put descriptive terms on the explanations of why discharges dropped. "Vague" is a fair term. Finally, the Intermediary argues that the interpretation presented in the Federal Register requires more than what has been presented to support the subsidy sought. An analysis of the non-exhaustive list of examples and without debating unusual versus extraordinary versus simply identifying a definitive situation or occurrence does provide a framework. The hospital must be the victim of a situation or occurrence which:

- Lowers the patient population base or the ability of the population to pay for care;
- Affects physical access to the hospital or damages the hospital to the extent that patients must go elsewhere; or
- The basic patient care resource for the hospital admission (physicians) are no longer in the community.

A variety of factors came into play and apparently led to different decisions made by potential patients. To the extent the culture of Integra and McFarland group practices influenced those decisions, the Intermediary's label as competition works to define what happened as well as any other description. Wider choices, too much paperwork, balky computers, and quirky personalities do not add up to support for the relief sought.

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[71] Tr. at 74.

[72] Tr. at 89.

[73] Tr. at 113.

[74] See Exhibits C & D to the Provider Exhibit 12; Tr. at 168.

[75] Tr. at 159, 160.

CITATION OF LAW, REGULATIONS & PROGRAM INSTRUCTIONS:

1. Law - Social Security Act

§ 1886(d)(5)(D)(iii)	-	Sole Community Hospital
§ 1886(d)(5)(G)(iii)	-	Medicare Dependent Small Rural Hospital

2. Regulations - 42 C.F.R.:

§§ 405.1835 - .1841	-	Board Jurisdiction
§ 412. 92	-	Special Treatment - Sole Community Hospital
§ 412.108(d)(2) et seq.	-	Additional Payments to Hospitals Experiencing a Significant Volume Decrease
§ 413.30(f)(2)	-	Extraordinary Circumstances
§ 413.40(g)(2)	-	Extraordinary Circumstances

3. Federal Register:

55 Fed. Reg. 15150 (April 20, 1990)	-	Special Payments Due to Circumstances Beyond Its Control

4. Program Instructions - Provider Reimbursement Manual (HCFA Pub. 15-1):

§ 2810.1	-	Additional Payments to SCHs that Experience a Decrease in Discharges

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The majority of the Board, after considering the Medicare law, regulations, program instructions, the facts, parties' contentions, evidence submitted and post-hearing briefs finds and concludes that the Provider is entitled to a payment adjustment due to a decline in discharges from FY 94 to FY 95. The Board majority finds that the amount of relief is $491,303. The majority also finds that the Provider took appropriate steps to identify the causes for its reduction in admissions. Further, the volume of discharges both at the Provider and at the county level increased in 1996.

The Board majority further finds that the wording of Social Security Act § 1886(d)(5)(G)(iii) and the Medicare regulation at 42 C.F.R. § 412.108(d)(2) essentially agree. Both contain the phrase

"circumstances beyond its control" as the foundation for additional payments for MDHs. In addition, HCFA Pub. 15-1 § 2810, which the Intermediary used as its basis to deny the Provider's payment adjustment, does not apply to this Provider's factual situation. The title to this section (Special Treatment of Sole Community Hospitals Under Prospective Payment System) clearly addresses Sole Community Hospitals, not MDHs. The Board majority does note that HCFA 15-1 § 2810.1 does provide a definition of "circumstances beyond the hospital's control." One of the examples offered is a provider's inability to recruit essential physician staff. If this Manual section did apply to the Provider, the Board majority finds that the Provider made reasonable attempts to recruit physicians. Appropriate examples included a loan to a physician to cover start-up costs of establishing a new practice, and an offer of office space to help another physician generate admissions. Thus, the Board majority finds that the Provider has met the definitional requirements of the above program instruction regarding circumstances beyond a provider's control.

The Board majority further finds that the reasons for the reduction in admissions identified by the Provider were beyond its control. The Provider could not control admissions of physicians who were involved in various practice changes. These included primary care physicians who joined a large medical practice as well as surgeons' admissions which were reduced because of the reduction in primary care referrals. Further, the Provider could not control admissions because physicians were preparing for retirement or were disgruntled employees. In fact, the Intermediary admitted that such admissions were beyond the Provider's control. In addition, there is nothing in the record that shows that there were any complaints by any physicians practicing at the Provider about the Provider's quality of service. Based on the above, the Board majority concludes that the statute and related regulation were established to grant relief to hospitals that have experienced patient volume declines as did the Provider. The additional payments made to MDHs are necessary to help them maintain viability as rural hospitals during periods of reduced admissions.

The Board majority finds the Intermediary's interpretations of the regulations, program instructions and regulation preamble as overly restrictive. The Intermediary's main argument is the wording of the preamble to 42 C.F.R. § 412.108(d)(2).[76] This language is similar to the requirements of HCFA Pub. 15-1 § 2810.1. It provides examples of unusual situations or occurrences that are both externally imposed on hospitals and beyond their control. The Intermediary interprets this preamble to relate to three types of circumstances. They are: (1) circumstances that make the hospital either physically inoperable or inaccessible; (2) economic circumstances which either change the community business environment or materially alter the level of financing for health coverage; and (3) inability to recruit essential staff. The Board majority finds this interpretation too restrictive. The preamble states that it may include certain circumstances as in the above situation. However, it also allows for other circumstances which the Board majority believes to be circumstances beyond the Provider's control. The Board majority has observed that the changes in market place conditions incurred were beyond the

[76] See 55 Fed. Reg. 15150, 15155 (April 20, 1990).

Provider's control. It could not control the changes in the type of physician arrangements that took place between FY 94 and FY 95. It could not control primary care physicians moving to group practices, surgeons referring patients to other facilities due to the change of primary care physicians and retirements of physicians. These were reasonable circumstances that were beyond the Provider's control.

The Board majority further finds that there were aberrations in market place conditions in that on a county wide basis admissions dropped in 1995 but later increased in 1996. Although unexplained, this helped create reduced admissions in FY 95. Finally, the Board majority notes that the Provider exercised "due diligence" when it determined that a reduction in admissions was inevitable and made attempts to obtain additional physicians through recruiting activities. That effort took some time to "bear fruit." However, the Provider's situation improved in FY 96 in response to that initiative.

DECISION AND ORDER:

The majority of the Board finds that the Provider is entitled to an adjustment payment due to a reduction in admissions. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING

Irvin W. Kues
Henry C. Wessman, Esquire (Dissenting Opinion - Joining)
Stanley J. Sokolove (Dissenting Opinion)
Dr. Gary B. Blodgett
Suzanne Cochran, Esquire

Date of Decision: August 02, 2002

FOR THE BOARD

Irvin W. Kues
Chairman

Dissenting Opinion of Stanley J. Sokolove, CPA

Section 1886(d)(5)(G)(iii) of the Act provides that if a Medicare dependent, small rural hospital experiences in a cost reporting period compared to the previous cost reporting period, "a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall adjust its payment amounts to fully compensate the hospital for the fixed costs it incurs in the period in providing hospital service"(emphasis added). The relief is for a period of one year only; it is not ongoing.

The predominant arguments presented by the Provider center around the inability of various physicians, that admit their patients to the Boone County Hospital, not being able to deal with the normal stresses of day to day business changes that all professionals are required to handle in order to survive in the healthcare industry.

Specifically it was argued that Drs. Murphy, Volker and Sutton joined Integra Health, a large group practice. There were staffing, recordkeeping and computerization issues that these individuals were faced with in this transition. As a result these physicians generated

81 fewer discharges in the 1995 fiscal year. The Provider's CEO was aware of this transition on January 1, 1994. Why did hospital management not provide consultation services in these vital areas to insure a smooth movement into this new group practice set up? There was a six month period prior to the start of the fiscal year at issue to tackle the problems being encountered.

The Provider has stated that Dr. Hardinger who joined the McFarland Clinic was disenchanted with his new arrangement and his compensation, and therefore discharged 36 fewer patients. Many professionals are not completely satisfied with their work environment, but in order to make a living they deal with adversity and still render a quality service in an efficient manner. The Provider lent $70,000 to another physician during this time frame, a Dr. Lorentzen, in order to keep her in the community. As a result, she was productive and her volume of admissions increased by 26. In addition, the Provider gave signing bonuses to two physicians who joined existing practices in the community. If financial incentives were spread equally to all physicians who were going through new transitions, and not in violation of any Stark law at 42 U.S.C. § 1395nn then maybe productivity would not have suffered.

Although Boone County Hospital experienced a decline in net income from $560,000 in fiscal 1994 to $132,000 in fiscal 1995, it was still a financially secure Provider as demonstrated by its financial statements in Exhibit P-1 of its Position Paper. Current assets at the end of fiscal 1995 were $3,873,412 and current liabilities were $ 1,672,538. The current ratio of 2.32 is evidence of a sound healthcare business and far superior to many healthcare organizations in the USA. The hospital had the resources to provide incentives equally to all physicians and not to just a chosen few which caused jealousy and discontent. I also ask why did it take the CEO until November, 1994 to determine that he had a problem? Monthly statistical reports from prior to the start of the fiscal year would have shown a negative trend.

In conclusion, I believe that the circumstances were not beyond the control of hospital management, and that Boone County Hospital is not entitled to a volume adjustment in accordance with the criteria of Section 1886(d)(5)(G)(iii) and 42 C.F.R.§ 412.108(d)(2).

Stanley J. Sokolove, CPA
Board Member

Wessman JOINING dissent

I JOIN the thoughtful and accurate Dissent of Board Member Sokolove, and wish to reinforce the following point.

While it is true that unrest among the Medical Staff of any given health care facility can have the impact of a force majure, it is not a force majure, because it is NOT beyond the control of the facility. 42 C.F.R. §412.108d(2)(ii) is clear on it's face, the bright line test for evaluating a hospital's request for a special payment is to be able to say that the 5% volume decrease was due to "circumstances beyond its control". In the instant case, Boone County Hospital has failed to demonstrate that the physician unrest was beyond the hospital's control, and the Intermediary adjustment is correct.

Care and feeding of medical staff is an integral and critical responsibility of any health care facility's administrative management group, and certainly within their control. Administrative staff is expected to be anticipatory, proactive, and creative when dealing with physicians who have a direct impact on both the physical health of the community, and the fiscal health of the hospital. To reward Boone County Hospital $490,000 in Medicare Trust Fund monies simply because the hospital could not work in harmony with it's own staff is just too liberal a stance for

this old conservative.

Henry C. Wessman, Esq.
Senior Board Member